SAN JOSE GASTROENTEROLOGY
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PATIENT REGISTRATION FORM

Date of Registration: _____ **Referring Physician:** _____

DEMOGRAPHIC

Patient's Name: _____ **Social Security No:** _____

Birthdate: _____ **Gender:** _____

Home Address: _____ Apt#: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone _____ **Cell Phone:** _____ **Work Phone:** _____

Email Address: _____

Preferred Contact (please check one): ☐ **Home Phone** ☐ **Cell Phone** ☐ **Work Phone** ☐ **Email**

Ethnicity: ☐African-American ☐Caucasian ☐Chinese ☐Filipino ☐Hispanic ☐Korean ☐Portuguese ☐Vietnamese ☐Other_____

Languages: ☐English ☐Chinese ☐French ☐Korean ☐Portuguese ☐Spanish ☐Tagalog ☐Vietnamese ☐Other_____

Preferred Pharmacy: (Name):_____ Phone: _____ - _____- _____
Pharmacy Address:

FAMILY INFORMATION

Name of Spouse:_____

Contact Person In Case Of Emergency_____**Relations:**_____**Phone #:**_____

Referred by (Name & Address):_____

Has any member of your immediate family has been treated by this office? Name if yes:_____

I hereby authorize the medical staff to be my attending physicians and to administer to me any examination treatment, and medications he or she deems therapeutic to my complaints. I hereby authorize the release of any information to insurance carriers to process my medical claims and I irrevocably assign to the doctors at San Jose Gastroenterology, MC all payments for medical services rendered. I understand that I am responsible for payments for services not covered by my insurance company.

_____ _____
Signature of Patient (or responsible party-please mark relation to patient) Date

Please choose ONE of the following choices below

I hereby authorize San Jose Gastroenterology, MC, its clinical staff and clerical staff, to discuss my medical information to any member of my family for the purposes of my medical care. _____ (Patient's signature)

OR

I hereby authorize San Jose Gastroenterology, MC, its clinical staff and clerical staff, to discuss my medical information ONLY to _____, my _____ (relationship). _____
(Patient's signature)

OR

I **do not** wish San Jose Gastroenterology, MC to discuss my medical information to anyone, except as permitted by privacy laws for the purposes of my medical care and insurance payments of my medical claims. _____
(Patient's signature)